

for self-only coverage and 67% $((12,000 - 4000)/12,000)$ for family coverage. For a subsequent plan year, the COBRA premium is \$6000 for self-only coverage and \$15,000 for family coverage. The employee contributions for that plan year are \$1200 for self-only coverage and \$5000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% $((6000 - 1200)/6000)$ for self-only coverage and 67% $((15,000 - 5000)/15,000)$ for family coverage.

(ii) *Conclusion.* In this *Example 8*, because there is no change in the contribution rate based on cost of coverage, the plan retains its status as a grandfathered health plan. The result would be the same if all or part of the employee contribution was made pre-tax through a cafeteria plan under section 125 of the Internal Revenue Code.

Example 9. (i) *Facts.* Before March 23, 2010, Employer *W* and Individual *B* enter into a legally binding employment contract that promises *B* lifetime health coverage upon termination. Prior to termination, *B* is covered by *W*'s self-insured grandfathered group health plan. *B* is terminated after March 23, 2010 and *W* purchases a new health insurance policy providing coverage to *B*, consistent with the terms of the employment contract.

(ii) *Conclusion.* In this *Example 9*, because no individual is enrolled in the health insurance policy on March 23, 2010, it is not a grandfathered health plan.

[75 FR 34566, June 17, 2010]

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

Subpart A—General Provisions

Sec.

148.101 Basis and purpose.

148.102 Scope, applicability, and effective dates.

148.103 Definitions.

Subpart B—Requirements Relating to Access and Renewability of Coverage

148.120 Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

148.122 Guaranteed renewability of individual health insurance coverage.

148.124 Certification and disclosure of coverage.

148.126 Determination of an eligible individual.

148.128 State flexibility in individual market reforms—alternative mechanisms.

Subpart C—Requirements Related to Benefits

148.170 Standards relating to benefits for mothers and newborns.

148.180 Prohibition of discrimination based on genetic information.

Subpart D—Preemption; Excepted Benefits

148.210 Preemption.

148.220 Excepted benefits.

Subpart E—Grants to States for Operation of Qualified High Risk Pools

148.306 Basis and scope.

148.308 Definitions.

148.310 Eligibility requirements for a grant.

148.312 Amount of grant payment.

148.314 Periods during which eligible States may apply for a grant.

148.316 Grant application instructions.

148.318 Grant application review.

148.320 Grant awards.

AUTHORITY: Secs. 2741 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg-41 through 300gg-63, 300gg-91, and 300gg-92).

SOURCE: 62 FR 16995, Apr. 8, 1997, unless otherwise noted.

Subpart A—General Provisions

§ 148.101 Basis and purpose.

This part implements sections 2741 through 2763 and 2791 and 2792 of the PHS Act. Its purpose is to improve access to individual health insurance coverage for certain eligible individuals who previously had group coverage, and to guarantee the renewability of all coverage in the individual market. It also provides certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth and protects all individuals and family members who have, or seek, individual health insurance coverage from discrimination based on genetic information.

[63 FR 57561, Oct. 27, 1998, as amended at 74 FR 51693, Oct. 7, 2009]

§ 148.102 Scope, applicability, and effective dates.

(a) *Scope and applicability.* (1) Individual health insurance coverage includes all health insurance coverage (as defined in §144.103) that is neither health insurance coverage sold in connection with an employment-related